Guidelines for OVHA Coverage

ITEM: REPAIRS/MODIFICATIONS FOR DME

DEFINITIONS: Repairs refers to the replacement of damaged or worn out parts of a piece of durable medical equipment. Modifications are changes to a piece of durable medical equipment that no longer meets the beneficiary's medical needs due to change in size, medical condition, living situation, or ability to perform basic functional activities of daily living.

GUIDELINES: Repairs are considered appropriate when:

- The beneficiary's equipment is no longer functioning properly AND
- The repair cost is less than 50% the cost of replacing the equipment AND
- The repair does not result in a change in the nature, structure, or function of the equipment as it was originally intended. Such change would be considered a modification and would require additional documentation from the medical practitioner to provide medical necessity justification for any changes.
- If a beneficiary has Medicare, but Medicare denied the purchase of the original piece of equipment, Medicaid will cover the cost of repair with proof of Medicare denial via a Medicare Explanation of Benefits form, which documents that the vendor has made a good-faith effort to acquire coverage from Medicare.
- The equipment must not be under warranty.
- If the beneficiary requires temporary replacement of the DME device during the repair period, this is provided under code K0462.
- The repair must be nonroutine and must require the skill of a technician.
- MODIFICATIONS: Regulation M841.3 states that "reimbursement for labor associated with custom fabrication of a seating system (a seat and or back with one other positioning component) will be made to the DME provider up to the limit of 5 hours." Administrative and clerical tasks, even if these tasks are performed by the technician, are not reimbursable.
- REPAIRS/MODIFICATIONS: Labor charges include travel time **for those beneficiaries who are not able to travel to the vendor's office or therapy department for the work needed.** The expectation is that beneficiaries will bring their equipment to their vendor's nearest office if at all possible. The travel 'benefit' is not for convenience but must be for medical necessity. It is also expected that the vendor, if billing for travel time, will make every effort to utilize travel time as efficaciously as possible by combining trips and traveling the least circuitous route. Medicaid should only be billed for the portion of the travel time that involves Medicaid clients. For example, if the technician has 3 client visits, and the second client is a Medicaid beneficiary, the expectation is that the technician will bill for travel time only between the first and second client's home. It is advised that providers keep technician's travel logs to be able to demonstrate compliance with this guideline in case of an audit.

APPLICABLE CODES:
V5014 Repair/modification of a hearing aid.

E1340 Repair or nonroutine service for DME, requiring the skill of a technician, labor component, per 15 minutes.
V5335 Repair of oral/laryngeal prosthesis
V5336 Repair/modification of augmentative communication system.
L4000-4130 Repair for specific part of orthosis
L4205 Repair of orthotic device, labor, per 15 minutes.
L4210 Repair of orthotic device, repair or replace minor parts
L7500 Repair of prosthetic device, hourly rate
L7510 Repair of prosthetic device, repair of replace minor parts
L7520 Repair prosthetic device, labor, per 15 minutes.
K0462 Temporary replacement for patient owned equipment being repaired, any type.

CAUTIONS: Significant caution must be used when a piece of DME such as a carseat or wheelchair has been involved in a major motor vehicle accident; that device may need to be replaced rather than repaired.

EXAMPLES OF DIAGNOSES: Any diagnosis that results in the need for DME.

REQUIRED DOCUMENTATION:

- Current, complete Certificate of Medical Necessity.
- Supporting documentation demonstrating that the beneficiary's equipment is no longer functioning properly AND
- That the repair cost is less than 50% the cost of replacing the equipment AND
- The repair does not result in a change in the nature, structure, or function of the equipment as it was originally intended. Such change would be considered a modification and would require additional documentation from the medical practitioner to provide medical necessity justification for any changes.
- If a beneficiary has Medicare, but Medicare denied the purchase of the original piece of equipment, Medicaid will cover the cost of repair with proof of Medicare denial via a Medicare Explanation of Benefits form, which documents that the vendor has made a good-faith effort to acquire coverage from Medicare.
- Documentation that the equipment must not be under warranty.
- Documentation of the medical necessity of temporary replacement of the DME device during the repair period including information on the MSRP pricing for the loaner equipment and the expected duration of the need for loaner equipment.
- Documentation signed by the technician itemizing billable time for all repairs requiring greater than 2 hours (8 units) of billed time, including travel time.
- Documentation of the medical necessity for travel time; documentation must demonstrate that the beneficiary can not travel to the vendor to get the equipment fixed. Providers should preserve technician's travel logs to demonstrate compliance with the guidelines above, in case of audit.

REFERENCES: Medicaid Policy Manual, WAM 841.3, and 650.5

Medical Director's signature: _____

OVHA Director's signature: _____

Date:
Revision 1:
Revision 2:
Revision 3: